

FILED DEC 23 1946

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10860**

1. PLACE OF DEATH:

(a) County **St. Louis**
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **St. Louis City Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME **Joe Smith**
 3. (b) If veteran, name war **Unknown** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **About 1983**
 (Month) (Day) (Year)

8. AGE: Years **About 63** Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace **Unknown Unknown**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Unemployed**

11. Industry or business _____

MOTHER FATHER { 12. Name **Unknown**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Otto Kollwitz**
 (b) Address **311 Elm St.**

17. (a) **Burial** (b) Date thereof **12-18-46**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe**
4700 Washington Blvd.
 (b) Address _____

19. (a) **DEC 18 1946** (Date received local registrar) **J. F. Bredenk** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **311 Elm St.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **17**
 year **1946** hour **2** minute **30** C.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Decompensated Cor Pulmonale
of the Liver
 Due to _____
 Due to _____

Duration

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **Bluest E. Taylor** (Specify type of place) _____ (c) Means of injury **3**
 Address **Dep. Coroner** Date signed **12/18/46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

NO EMBALM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.